

MEDICAL SUPPORT TO FAILED STATES: START WITH THE PRISONS

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ABSTRACT

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The instability created by the collapse of the bipolar world and globalization has dramatically increased the number of failed states. These countries suffer from social, political, economic and human rights instability which threaten the safety of their populations, the stability of their regions and potentially, the security of the world. The key to stabilizing these states is to develop good governance which supports the Rule of Law, provides internal and border security, fosters economic development and improves the distribution of essential services. The 2009 DODI 3000.05 on Stability Operations and subsequent DODI 6000.16 on Medical Stability Operations elevate these missions to equivalency with Combat Operations. It is the thesis of this paper that the most effective avenue for the Military Health System to support failing states is through the enhancement of the Rule of Law operations. Specifically, the US Army Medical Department should increase its efforts in partnering with the Interagency, Military Police, Peace Keeping and Support Operations Institute and NGO's to support the development of humane prison systems.

MEDICAL SUPPORT TO FAILED STATES: START WITH THE PRISONS

In an era of economic fragility, the cost of nation building has become more than the developed world can bear. Yet the instability created by the collapse of the bipolar world and globalization continues to increase the number of failed states and the threat they portend. The 2010 Failed State Index lists 37 countries with a combined population of over 2 billion in alert status¹. These countries suffer from social, political, economic and human rights instability which threaten the safety of their populations, the stability of their regions and potentially, the security of the world.

Failed states can pose a threat to the security of the U.S. by denying access to critical resources; acting as transshipment points for illegal weapons, drugs and people; serving as staging, training and recruiting areas for Al Qaeda or its affiliates; and destabilizing regions via population migrations, disease or conflict. The key to stabilizing these states is to develop good governance which supports the Rule of Law, provides internal and border security, promotes economic development and improves the distribution of essential services. This is no small task as many failing states gained independence after the exit of their colonial masters and never possessed the structure and capacity to govern. Additionally many of these states are confronted with arbitrary boundaries splitting tribes, cultures and religious groups which promote conflict. The bipolar world served to temporarily stabilize those governments through large influxes of money and weapons, but left good governance to chance. The largest recipients of Cold War arms are today's leaders on the Failed State Index (Angola, Chad, Ethiopia, Liberia, Mozambique, Somalia, Sudan and Zaire). Developing good governance and stability requires long term commitments of resources. Extrapolating from RAND

figures, the approximate cost of nation building for the top 5 states in the Failed State Index would amount to \$54 billion per year in a permissive environment and \$454 billion per year in peace enforcement conditions.²

The US has a long history of military intervention in Failed States. During the Cold War, the primary motivation was the containment of Communism – Vietnam (1954), Lebanon (1958), Dominican Republic (1963), Grenada (1983), but also peacekeeping in Lebanon (1982) and regime change in Panama (1989). In the post Cold War years intervention has been spurred by humanitarian crises - Somalia (1992) and Haiti (2010); peace enforcement – Bosnia (1995) and Kosovo (1999); the defeat of global terrorism – Afghanistan (2001) and Iraq (2003); and to facilitate the transition of power while preventing humanitarian crisis - Haiti (1994). The U.S. also has a history of declining to intervene in Failed States such as Rwanda (1994) during the Tutsi genocide and Sudan during the civil war and genocide when vital national interests were not involved.

With the U.S.'s history of involvement and its current position as the sole super power, largest world economy and primary target of Islamic extremism, the opportunities to intervene in failed states will be myriad; the question is how to engage. With the distribution of Department of Defense Instruction (DODI) 6000.16, Medical Health System (MHS) Support for Stability Operations, in May 2010, the military's health care leaders have been tasked to determine a method. This paper proposes that military medical support to the Rule of Law efforts, specifically; the provision of medical care in prisons is an effective engagement process for the MHS in support of failed state intervention.

Failed State Policy to DOD Instruction

It was not until after the interventions in Haiti, Northern Iraq, the Balkans, and the tragedies in Rwanda and Somalia that President Clinton issued the first Presidential Decision Directive (PDD), Number 56 in May 1997, establishing an interagency process for managing “complex contingency operations.” In spite of this neither the Department of State (DOS) nor the Department of Defense (DOD) created any standing machinery, training or guidelines for carrying them out.³ While President Clinton’s second National Security Strategy identified failed states as havens for terrorists and acknowledged that preventing their failure was more cost effective than rebuilding them; it was President George W. Bush who altered the U.S.’s fundamental approach to these states with the creation of the Millennium Challenge Account (MCA).^{4 5} The Bush Administration replaced the practice of providing massive, poorly focused, developmental assistance money to failing states with the MCA that rewarded good governance which embraced the Rule of Law.⁶

In recognition of the DOD’s post conflict reconstruction difficulties in Iraq and Afghanistan, President Bush also issued National Security Presidential Directive – 44 which identified security in combination with the Rule of Law as the critical admixtures in stabilizing fragile states. It assigned the DOS the lead in post-conflict interventions and led to the creation of the Civilian Reserve Corps (CRC) with police, constabulary, and Rule of Law experts to assist the U.S. military. The directive sought to fill the gap in trained and equipped civilian Rule of Law assets revealed by the current stability operations.⁷

NSPD-44 led to a reverse in the DOD’s post-Vietnam avoidance of nation building. The DOD responded to NSPD-44 by reversing its post-Vietnam avoidance of

nation building and issuing Directive 3000.05 that instructed the military to “be prepared to conduct [stability operations] with proficiency equivalent to combat operations.”⁸ A critical goal identified within this Directive was to aid in the development of the indigenous capacity for the Rule of Law to include the rebuilding of correctional facilities.⁹

The Obama administration reinforced the “whole of government” approach and issued DODI 3000.05 which extended the military’s mission from security and critical essential services in the emergency response period to assisting in reconciliation, strengthening governance and the Rule of Law and fostering economic development.¹⁰

¹¹ Despite emphasizing the DOD’s role in assisting the establishment of the Rule of Law, the document dropped the direct reference to correctional facilities from DODD 3000.05. This may have reflected the Obama Administration’s sensitivities over the prison in Guantanamo and the previous Administration’s policy of enhanced interrogation techniques.

In May 2010 the Military Health System (MHS) responded to its tasking from the DODI 3000.05 by publishing DODI 6000.16, Medical Health System (MHS) Support for Stability Operations. It required the MHS to prepare “to establish, reconstitute, and maintain health sector capacity and capability for the indigenous population when indigenous, foreign, or U.S. civilian professionals cannot do so.” This requirement was to be executed in combat and non-combat environments and in collaboration with interagency, international, public and private organizations.¹² The specifics of what type of capabilities to organize, train and equip were left to the Services to develop.¹³

Rule of Law

Executing the U.S. policy aims of stabilizing Fragile/Failed states and developing the MHS policy to meet that desired end state is difficult work. The opening line of Tolstoy's *Anna Karenina*, "All happy families are alike; each unhappy family is unhappy in its own way," applies aptly to Failing States.¹⁴¹⁵ Each Failing State suffers from a breakdown in a critical element(s) of statehood; either legitimacy, the right to govern, and/or effectiveness, the ability to provide essential services to the governed.¹⁶ Each of these elements is multifaceted and interrelated. One element common to both legitimacy and effectiveness is the Rule of Law.

The Rule of Law (ROL) is the principle that the government, its institutions, private entities and the governed are accountable to the laws. It is a key end state in stability operations as well as counterinsurgency.¹⁷ The core tenet in ROL is that laws "are publically promulgated, equally enforced, independently adjudicated and are consistent with international human rights norms and standards."¹⁸ Meeting that standard strengthens the people's confidence in the government (legitimacy) and allows the government to more efficiently provide services to the people (effectiveness). Abandoning the effort to attain that benchmark means criminal violence increases, bribes inflate the costs of goods, medicines do not reach hospitals and the people are exploited. The ROL is the cornerstone to ensuring physical security, safeguarding community participation, improving public health and fighting poverty.¹⁹

A key element in the ROL is a functional and humane prison system. As the U.S. and European Union (EU) discovered in the Balkans, promulgating sound laws, applying them fairly and then having no facility or an unsafe corrections facility to house offenders does not move the process forward. In the Balkans the U.S. and the EU

launched an aggressive campaign to rebuild the local police. International Criminal Investigative Training Assistance Program (ICITAP) successfully introduced community-oriented policing which dramatically controlled street crime. Unfortunately the same effort was not applied to the other parts of the judicial system to include the prisons. The result was an inability to cope with organized crime over the long haul.²⁰

In Haiti a similar situation exists today. After 15 years of U.S. assistance in developing the Haitian National Police, the police are rated by Haitians as the most trusted and competent public institution in the country. However the country continues to have one of “the highest pre-trial detention rates in the world and a prison system fraught with human rights violations.”²¹

Medical Care in Prisons

Efforts aimed at professionalizing the corrections field are often the lowest priority. Efforts to improve the care provided to pre-trial detainees or prisoners fall even lower. Sadly this statement applies even in the U.S. with one of the richest medical enterprises in the world; health care often fails to trickle down to the incarcerated. It was not until 1976, in the U.S. Supreme Court decision in *Estelle v. Gamble* that it was deemed unconstitutional to deny medically necessary care to a prisoner.²² By application of the Fourteenth Amendment (*Bell v. Wolfish*, 1979) this precedent was extended to pretrial detainees.²³ In Fragile nations the scenario is worse. Prisons have a critical shortage of physicians, medical supplies and in some case medical care all together. The concept that prisoners do not give up their human rights when they enter prison or detention is an idea with incomplete permeation throughout the world.

The lack of focus on prisoner health care extends even to charitable organizations which avoid association with the facilities. *Medecins Sans Frontier* which

received over \$286 million in donations from U.S. citizens in 2008 and 2009 reported intervening in prisons in only four countries; providing nutrition assistance in two and HIV/AIDs and Cholera assistance in the others.²⁴ Similarly, the largest prison oriented international charity, Prison Fellowship International, has provided only \$10 million in medicines and equipment to prisons through assistance visits to 30 countries since 1994.²⁵

Care provided to prisoners is not an empty gesture of kindness. It may save lives and prevent disease miles and months distant from prison. Over 95% of prisoners will be released to the community, bringing with them their illnesses. The impact of prevention and education on that population can be significant. In Russia overcrowded prisons have bred new drug-resistant strains of tuberculosis that have proliferated virulently among the general public.²⁶ Similarly in the early 1990's the Los Angeles Jail experienced an outbreak of cerebral meningitis that spread to the local community.²⁷ In the Failed States of Africa, the spread of drug resistant Tuberculosis and HIV in the prisons now pose a grave threat to the region. Multidrug resistant TB that proliferates in prison populations and then spreads to the community through the prison staff and visitors is defeating efforts to control TB in the region.²⁸ Similarly in sub Saharan Africa which is home to two-thirds of the world's HIV cases, the rates of HIV in prisons are two to fifty times those in the community.²⁹ The maxim, "Good prison health is good community health," is reflected in these examples.

The other benefit of health care is "care." Treating humans with dignity and respect is a common language of reconciliation. Former UN Secretary General Kofi Annan noted that "to avoid a return to conflict while laying a solid foundation for

development, emphasis must be placed on critical priorities such as ...demonstrating respect for human rights.”³⁰ Those held in Failed State prisons may be the next generation of terrorists or community leaders depending on the treatment that they receive. In Operation Iraqi Freedom Major General Douglas Stone upended four years of warehousing detainees in vast holding areas and instead sought to “Win Hearts and Minds” in the detention facilities. His efforts were designed to defeat the current “jihadi university” which had taken hold in the Coalition detention centers in Iraq. Key to his efforts was the invigoration of programs aimed at treating the detainees with dignity and respect. Figuring centrally along with education programs were improvements in medical care.³¹ The results of this initiative were a dramatic decline in internment facility violence and a recidivism rate reported by Major General Stone of one percent.³²

The impact of medical personnel treating a prisoner with dignity and respect is difficult to quantify with certainty, but the presence of a prisoner advocate may be significant. In the infamous 1971 Stanford Prison Study, 24 college undergraduates were randomly selected to serve as prisoners or guards in a two-week behavioral lab. The experiment was halted after only six days when a psychologist brought in to conduct interviews with the prisoners and guards objected to the prisoner’s treatment.³³ The abuses of power in the Stanford experiment produced situations uncomfortably similar to those reported in the 2004 Abu Ghraib Taguba Report.³⁴ The experiment demonstrated both the corrosive effects of unrestrained power and also the impact of a single morale sentinel.

The humane treatment of prisoners may have longer term and more extensive consequences when two other factors are considered. Firstly, the majority of those

incarcerated in Failed State prisons have never been convicted of any crime. Although the U.S. currently has the highest per capita incarceration rate, the leaders in total number of detained persons are the Failed States. Because of the lack of effective judiciary branches in these countries, not only is the numbers of detainees high, but so is the length of their pretrial detention. In multiple countries, over three quarters of all prisoners are pretrial detainees and their length of detention can last years. These “unconvicted” make up a large portion of the 30 million men and women incarcerated each year worldwide.³⁵

The second group that extend the impact of providing humane treatment to prisoners are the list of former prisoners turned national leaders. Perhaps most well known is Nelson Mandela, the former president of South African who served 14 years in Robben Island prison. In addition to Mandela there is Dilma Rousseff, president of Brazil, a prisoner for five years, Vaclav Haval, Lech Walesa, Moshe Dayan, Ayman Nour, and Benazir Bhutto. Many times this number of former prisoners is serving in less visible posts.³⁶ The impact of the health care and the manner it is delivered can have a significant effect on their ability and desire to support their country once released.

The improvement of access to medical care for prisoners can also elevate the quality of the corrections care via indirect mechanisms. The provision of basic care in Fragile State prisons is dependent on the corrections officers. In Zimbabwe “trained, experienced prison officers have left the service in the thousands. Officers are not paid remotely enough to feed themselves – attendance at work is erratic and prison supplies are stolen.”³⁷ RAND figures conclude that to maintain a quality security or corrections force, salaries must be approximately three times the Gross Domestic product per

capita.³⁸ Utilizing health officers to provide care to the correction officers and their families serves as a salary substitute or augmentation, as well as a retention tool and preventive medical measure. The benefit to the institution of maintaining well trained, professional and caring correction officers is substantial.

Military Health System Intervention in Failed State Prisons

The need for interventions in Failed State prisons is evident, but is it a valid course of action for the Military Health System? Would this new approach be of more value than are our current MHS approaches in supporting the legitimacy and effectiveness of the fragile state?

The US military has the unique ability to project health care to any point on the globe. The arrival of the US Navy's Hospital Ship Mercy or Comfort at the scene of devastation provides an immediate elevation of the health care capability. The establishment of an Air Force Expeditionary hospital or Army Combat Support Hospital provides a similar impact on the local care, but how do they contribute to the host nation's legitimacy or effectiveness?

Although "Winning Hearts and Minds" is crucial to establishing a government's legitimacy there is no data to suggest that medical care provided by a third country transfers legitimacy to the Host Nation (HN). Moshe Dayan pointedly commented when reviewing the U.S. efforts in Vietnam, that "foreign troops never win the hearts of the people."³⁹ Positioning a HN care provider in the forefront of an American medical outreach project may appear to remedy this problem, but unless the HN can support the medical activity long term, any legitimacy gained by the perception will be lost. The current consensus is that governments or donors responding to health crises in failed states must move as rapidly as possible from providing emergency health services to

supporting the growth in the state's health capacity. Foreign entities must work with and through the nation's ministry of health to implement a comprehensive primary care based health system.⁴⁰

Another compelling argument against the stop-gap medical care approach to intervening in failing states is provided by USAID. A June 2006 study titled "Basic Health Programming in post conflict Fragile States," reviewed crude mortality data from the Democratic Republic of Congo. Their conclusions were that, "reductions in crude mortality are closely associated with reductions in violence and, by extension, improvements in security . . ." and that "these trends... provide compelling evidence that improvements in security represent perhaps the most effective means to reduce excess mortality." The USAID study draws the implication that programs that aid in effecting a ceasefire or assist the peace process are more important in the immediate, highly fragile, post-conflict setting than the provision of emergency health services.⁴¹

If emergency medical support is not the answer, how can the MHS aid in capacity building? The U.S. military has experience with attempting to build HN health system capacity. During the Vietnam War, the U.S. approached this goal through multiple programs. The best known and least effective was the Medical Civic Action Program, known as the MEDCAP. The MEDCAP deployed military medical personnel from large American troop concentrations to nearby villages for very short periods, sometimes as short as hours, to provide primary care to the South Vietnamese. The quality of health care provided was poor owing to the lack of diagnostic tools, translation difficulties, poor follow-up and absence of medical records, but most significantly the programs did nothing to increase South Vietnam's health care capacity. A lesser known

program conducted during the same period under the auspices of USAID was the Military Provincial Hospital Augmentation Program (MILPHAP). MILPHAP, begun in 1965 deployed military and civilian medical personnel to provincial hospitals far from the large American bases. The mission of the sixteen man teams was to “provide medical care and health services to Vietnamese civilians, train hospital staff workers and develop the surgical skills of the Vietnamese physicians.”⁴² MILPHAP did upgrade hospital care in particular in the surgical specialties and increased the availability of these treatments to the population, but it was hamstrung by supply shortages, personnel rotation policies and most significantly, security problems.⁴³

Today the risk of placing military medical personnel in poorly secured Failed State health facilities is significant. The reality is that providing Humanitarian Care or developing long term health capacity comes with risks. In 2008, the chances of a Humanitarian Aid worker dying of violence were six times higher than those of a U.S. police officer.⁴⁴ There were 260 humanitarian aid workers killed, kidnapped or seriously injured in violent attacks – the highest yearly toll on record. All of these attacks occurred in Failed or Fragile States. Kidnappings which are of special sensitivity to deployed military forces saw a 350% increase among humanitarian workers from 2006 to 2008. In fact, it was more dangerous to be a humanitarian worker than a U.N. peacekeeper in 2008.⁴⁵ These facts all point to the need for security of medical providers and public health experts engaged in long term capacity building. Security is manpower intensive; devising ways to provide care and develop public health capacity with the smallest logistical or security tail is critical to the sustainability of projects. In permissive

environments the security of individual medical personnel may be of less priority, but few of the Failed/Fragile states enter into this category.

Another possible avenue to augment the health capacity of the Failed/Fragile state is through direct training of their medical personnel either in the HN or at distant locations. The military has pursued this course of action since the conclusion of World War II when Korean medical students were brought to the U.S. to train and continues in the form of International Military Education and Training. The medical training of individual physicians in Failed States develops little essential service capacity and may contribute to the epidemic-like flight of physicians from these states. Over 3,000 Ethiopian physicians have fled to practice in Botswana, South Africa and the Middle East, leaving only 900 physicians to care for Ethiopia's population of over 90 million. In fact, there are more Ethiopian physicians practicing in Chicago, than in Ethiopia.^{46 47}

Thus far the reasons for intervening in Failed State prisons have focused on the obvious needs of the imprisoned, the benefit to the community *writ large* and the intervention's relative value when compared to the historical MHS approaches. There are also compelling reasons to develop this interventional capability even if other methods are used.

First, the international community holds the U.S. accountable for the actions of the nations that we support through financial or training intervention. This fact was clearly evident in the controversy in the late 20th century over the U.S. School of the Americas and its link to torture and deaths in Central and South America.

Secondly, in every intervention in a Failed State, the U.S. has detained host nation individuals and confronted difficulties in securing them in the HN correctional

facilities. In Somalia during Operation Restore Hope it became evident within the first few days that the Unified Task Force could not rely on the host nation judiciary or police force to detainee criminals. For this reason a 20 person holding facility was established at U.S. Support Command headquarters.⁴⁸ In Kosovo a similar situation was encountered in the 1999 Operation Allied Force. The HN correctional facilities were found to be uninhabitable, destroyed by bombing or arson. NATO forces ended up using police holding cells or securing detainees in NATO tents behind barbed wire.⁴⁹ Even in non-conflict related interventions detention operations may be required. In the January 2010 earthquake in Haiti, the National Penitentiary in Port-au-Prince was destroyed, releasing all of the 4,000 prisoners.⁵⁰

The U.S. is compelled to enter into detention operations, not simply because of a lack of physical facilities, but because of international law. Article 12 of the Geneva Convention Relative to the Treatment of Prisoners of War requires that “prisoners of war may only be transferred by the Detaining Power to a Power which is a party to the Convention and after the Detaining Power (GPW) has satisfied itself of the willingness and ability of such transferee Power to apply the Convention.”⁵¹ Thus the U.S. must ensure that their detainees are being held in humane conditions which comply with International Human Rights standards. The ramifications of this responsibility were seen in the Vietnam War, Afghanistan, and Iraq.

In Vietnam, unlike previous wars, the U.S. Army did not establish a network of prisoner-of-war camps. Instead the U.S. transferred all captured individuals to the South Vietnamese custody. To comply with Article 12 GPW, the U.S. pressured the government of South Vietnam to cooperate with International Committee of the Red

Cross visits and assigned U.S. Army Military Police advisory teams to assist and ensure Geneva Convention compliance.⁵²

In Afghanistan the Canadians applied the first half of Article 12 without following up on the second half. They established the policy in 2002 of turning over all detainees to the Afghan authorities after concerns over the U.S. treatment of detainees. The Canadians however failed to ensure Afghan compliance with GPW and landed in controversy when it was discovered that one of the detainees turned over to the Afghans had been tortured.⁵³

When the Strategic Framework Agreement was implemented on January 01, 2009 in Iraq, the Al-Maliki government took legal custody of the over 15,000 detainees in Coalition control. The process of transferring them to Iraqi prison facilities began on February 01, 2009 and required inspections of the receiving facilities. Brigadier General Quantock, the Commanding General of Task Force 134 (Detainee Operations) stated that “Every one of these centers meets minimum human rights standards.”⁵⁴

Doctrine and the Law

The U.S. Army as the Executive Agent for the administration of the DOD Detainee Program recognizes the criticality of providing humane treatment to detainees and prisoners. The key doctrinal publications documents Field Manual (FM) 3-07, *Stability Operations*, FM 3-24, *Counterinsurgency*, and FM 3-39.40, *Internment and Resettlement Operations (I/R)*, anticipate the poor state of prisons and inhumane conditions that U.S. Armed Forces may encounter when intervening in Failed States as well as the criticality of treating prisoners and detainees humanely.⁵⁵ FM 3-39.40 published in February 2010 offers a dramatic vision of what professionally and humanely conducted internment operations can achieve. The manual postulates that

internment operations can “deter, mitigate, and defeat threats to populations that may result in conflict; reverse conditions of human suffering; and build the capacity of a foreign government to effectively care for and govern its population.”⁵⁶ Although vision and reality rarely coincide, doctrinal statements written after eight years of intensive experience need to receive serious consideration.

U.S. law under Title 22 U.S.Code 2240 currently presents an obstacle to an increase in military involvement in prison medical support. The law prohibits the use of foreign assistance funds “to provide training or advice, or provide any financial support, for police, prisons, or other law enforcement forces for any foreign government or any program of internal intelligence or surveillance on behalf of any foreign government within the United States or abroad.”⁵⁷ There is, however, an exception within the law which permits funds to be used to reconstitute civilian police capability in post-conflict periods. The goal must be to support the nation emerging from instability and must include training in human rights and the Rule of Law amongst other stipulations.

In recognition of the current inhumane conditions in many countries that receive U.S. Foreign Assistance money, the Senate introduced Bill 3798, “The Foreign Prison Conditions Improvement Act of 2010.” The bill sponsored by Senator Patrick Leahy of Vermont, which has been reported out from committee in December of 2010 authorizes “appropriations of United States assistance to help eliminate conditions in foreign prisons and other detention facilities that do not meet minimum human standards of health, sanitation, and safety, and for other purposes.”⁵⁸ It would add an exception to the Title 22 U.S.C. 2240 to allow this assistance. The companion House Resolution

6153 was referred to committee in September 2010 and four of the five cosponsors remain in the House for the 112th Congress.

Recommendations

The U.S. military is well prepared to engage in medical support to corrections or detention operations as adviser or trainers. Military health care providers now have extensive experience in caring for detained populations in Iraq and Afghanistan since 2001. Although the daily practice of medicine varies greatly from developed to undeveloped world the underlying principles of prevention, diagnosis and treatment in a relationship of dignity and respect do not. Corporately, the current MHS leadership's focus on prevention, protection, community health and cost containment is directly transferable to the key issues confronting Failed State prisons.⁵⁹ As the MHS begins to develop strategies to efficiently and effectively support stability operations, health support of Rule of Law efforts must be considered on par with those used historically. To accomplish this effort the following recommendations are made:

1. Doctrine. With the Army as the Executive Agent for Detention Operations and the lead military branch engaged in COIN, the Army must invest in a redrafting of FM 8-42, *Medical Support to Stability Operations*, with specific focus on capacity building options. Dedicating a section on medical support to the Rule of Law in corrections capacity projects would be ideal.

2. Organization. Assign the AMEDD Center and School the responsibility of maintaining subject matter expertise medical support to failed state corrections operations. The AMEDD Center and School must maintain a close liaison with the United States Army Peacekeeping and Stability and Support Operations Institute at Carlisle Barracks and the US Army Military Police School at Fort Leonard Wood to

gather the most current policy, procedures and lessons learned from medical support to detention operations and Rule of Law operations.

3. Training and Education. Physicians trained in developed countries have different practice patterns than those in undeveloped and resource constrained areas. The AMEDD C&S in conjunction with the U.S. Army Public Health Command would need to develop an austere Preventive Medicine and Primary Care medical course. The MHS currently supports multiple courses which cover Tropical, Global and Preventive Medicine. Tailoring them to the needs and resources of Failed States would require consultation with USAID and NGO's who specialize in providing this type of service.

4. Leadership. As directed by DODI 6000.16 the MHS is authorized to assign personnel to assignments and training with "relevant U.S. Government departments and agencies, foreign governments and security forces, IOs, NGOs, and members of the Private Sector."⁶⁰ Assigning AMEDD personnel to the work with the Department of States Civilian Response Corps or ICITAP to facilitate planning of operations and additional personnel training would be consistent and beneficial.

Conclusions

Since the end of the Second World War the U.S.'s approach to stabilizing fragile states has consisted of economic aid, assistance with essential services and the equipping and professionalizing of security forces. Current events in the Middle East call into question that approach. The citizens of Tunisia, Egypt, Yemen, Libya, and Bahrain are not protesting the lack of a well trained army, access to medical care or shortages of foreign sponsored development, but ubiquitous corruption, a failure of the Rule of Law. In the U.S. we envision corruption as a back room pay off to gain an advantage, but in many Failed States corruption is the price of survival both for the extorted and the

official. That increased cost of daily transactions raises the price of all commodities, limits economic opportunities, restricts access to healthcare and darkens the prospects of the next generation. The answer to corruption is not increased economic aid or military training, but international support for the Rule of Law.

Just as the mortality data from the Democratic Republic of Congo points out that the best form of health care in conflict torn states is care that helps to end the violence; the best approach for medical intervention in failing states is that which supports the establishment of the Rule of Law. No visit by an American medical team, clinic engineering project or vaccination campaign can solve the festering problem of humans living in a society with unequal enforcement of its own laws. The U.S. government is working with other nations to improve the Rule of Law by developing professional and impartial judges, police and guards. The Military Health System can aid in this endeavor by extend training and support to corrections medical staff in order to supply care to those imprisoned in Fragile or Failed States. Such an intervention will bestow a myriad of benefits beginning with the health of the prisoner and correction facility, but extending to the local, regional and potentially international community. The U.S. will reap the rewards of stabilized states and international approval for its demonstration of unwavering support for human rights.

Tolstoy's quote from Anna Karenina points to the reality that solutions to problems in complex systems are never simple or clearly evident. System theorists refer to those solutions as leverage points; the actions or changes in underlying structure that lead to significant and enduring improvements.⁶¹ Discovering a leverage point is a challenging task as it is usually separated in time and space from its effect. Caring for

the most vulnerable is an act that resonates with all individuals whether elite or struggling, and from businessman to bureaucrat. Providing that care to the defenseless, imprisoned populations in Failed States is not only be a noble gesture, but a key leverage point to support Rule of Law efforts which advances the legitimacy and effectiveness of those nations.

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